

Salt Lake County
Division of Substance Abuse Services

REFERRAL FOR MEDICATION EVALUATION

Name of Referring Agency: _____
Name of Referring Licensed Mental Health Professional: _____
Full Address of Agency: _____

Client's Full Name: _____ MIS Number: _____
Client's Social Security Number: _____ Date of Birth: _____
Client's Last Known Address: _____
County: _____ State: _____
Client's Funding Code: _____ ASAM Level: _____
Date Client Entered Treatment: _____ Date of Last Use of Alcohol and/or Drugs: _____

Presenting problem and reason for referral: _____

Please list all medications the client currently is taking including over the counter meds:

Medication	Dose	Frequency	Prescribing MD	Phone Number
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please list all psychiatric medication the client has been prescribed in the past:

Medication	Dose	Frequency	Prescribing MD	Phone Number
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please check all that apply:

Behavior:	Mood:	Affect:	Mental Status:
<input type="checkbox"/> withdrawn/isolating	<input type="checkbox"/> poor concentration	<input type="checkbox"/> flat	<input type="checkbox"/> auditory hallucinations
<input type="checkbox"/> acting out	<input type="checkbox"/> helpless	<input type="checkbox"/> inappropriate	<input type="checkbox"/> paranoia
<input type="checkbox"/> suicidal	<input type="checkbox"/> hopeless	<input type="checkbox"/> blunted	<input type="checkbox"/> visual hallucinations
<input type="checkbox"/> tearful	<input type="checkbox"/> sad	<input type="checkbox"/> labile	<input type="checkbox"/> delusions
<input type="checkbox"/> peculiar	<input type="checkbox"/> anxious	<input type="checkbox"/> normal	<input type="checkbox"/> memory difficulties
<input type="checkbox"/> excessive sleep	<input type="checkbox"/> angry		<input type="checkbox"/> racing thoughts
<input type="checkbox"/> difficulty sleeping	<input type="checkbox"/> irritable		<input type="checkbox"/> inappropriate speed
<input type="checkbox"/> excessive energy	<input type="checkbox"/> euphoric		
<input type="checkbox"/> change in appetite	<input type="checkbox"/> depressed		
<input type="checkbox"/> history of violence			

Referral must be signed by a Licensed Mental Health Professional and include a two-way release of information.

It is my clinical impression that the above referred client has a mental illness and requires a medication evaluation.

Signature of Mental Health Professional Phone Number

Contact Person (If Different) Phone Number

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